DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED

HEALTH CARE FINANCING ADMINISTRATION OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL	1. TRANSMITTAL NUMBER: **02-47** 2. STATE: **New York**
FOR: HEALTH CARE FINANCING ADMINISTRATION	3. PROGRAM IDENTIFICATION: **TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)**
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE **October 1, 2002**

5. TYPE OF PLAN MATERIAL *(Check One)*:

NEW STATE PLAN AMENDMENT TO BE CONSIDERED AS NEW PLAN AMENDMENT **XX**

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION: **Section 1902(a) of the Social Security Act**	7. FEDERAL BUDGET IMPACT: a. FFY **2002-2003** **$0** b. FFY **2003-2004** **$0**
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Attachment 4.19B, Page 2(c)(iv)**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT: **Attachment 4.19B, Page 2(c)(iv)**

10. SUBJECT OF AMENDMENT: **Non-Institutional Services, Payments for Federally Qualified Health Care Centers – Recruitment & Retention Services**

11. GOVERNOR'S REVIEW *(Check One)*:

GOVERNOR'S OFFICE REPORTED NO COMMENT OTHER, AS SPECIFIED:

COMMENTS OF GOVERNOR'S OFFICE ENCLOSED **xxx**

NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL: S. Pettinato	16. RETURN TO: **New York State Department of Health, Corning Tower, Empire State Plaza, Albany NY 12237**
13. TYPED NAME: for **Kathryn L. Kuhmerker**	
14. TITLE: **Deputy Commissioner, Office of Medicaid Management**	
15. DATE SUBMITTED: August 6, 2002	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:	18. DATE APPROVED:

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 10/01/02	20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: Sue Kelly	22. TITLE: Associate Regional Administrator Division of Medicaid and State Operations

23. REMARKS:

As per State letter dated 11/19/02, newly submitted page will replace page that was originally submitted with SPA. The SPA is now being approved with above stated change.

According to the Paperwork reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The OMB control number for this information collection is 0938-0193. The time required to complete this information collection is 10 hours (or minutes) per response, including the time to review instructions, search existing data resources, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: HCFA, 7500 Security Boulevard, N2-14-26, Baltimore, Maryland 21244-1850 and to the Office of the Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

Prospective Payment System Reimbursement as of 1 January 2001 for Federally Qualified Health Center (FQHCs) and Rural Health Clinics Including FQHCs Located on Native American Reservations and Operated by Native American Tribes or Tribal Organizations Pursuant To Applicable Federal Law And For Which State Licensure Is Not Required

For services provided on and after January 1, 2001 and prior to October 1, 2001, all-inclusive rates shall be calculated by the Department of Health, based on the lower of the facilities' allowable operating cost per visit or the peer group ceiling plus allowable capital cost per visit. The base for this calculation shall be the average of cost data submitted by facilities for both the 1999 and 2000 base years.

For each twelve month period following September 30, 2001, the operating cost component of such rates of payment shall reflect the operating cost component in effect on September thirtieth of the prior period as increased by the percentage increase in the Medicare Economic Index and as adjusted pursuant to applicable regulations to take into account any increase or decrease in the scope of services furnished by the facility.

Supplementary increases in Medicaid rates of payment for these providers which is paid for the purpose of recruitment and retention of non-supervisory workers or workers with direct patient care responsibility, in accordance with the provisions of page 2(c)(vii) of this attachment, are in addition to the standard Medicaid operating cost component calculation. As such, they are not subject to trend adjustments.

Rates of payments to facilities which first qualify as federally qualified health centers on or after October 1, 2000 shall be computed as above provided, however, that the operating cost component of such rates shall reflect an average of the operating cost components of rates of payments issued to other FQHC facilities during the same rate period and in the same geographic region, and with similar case load, and further provided that the capital cost component of such rates shall reflect the most recently available capital cost data for such facility as reported to the Department of Health. For each twelve-month period following the rate period in which such facilities commence operation, the operating cost components of rates of payment for such facilities shall be computed as described above.

For services provided on or after January 1, 2001, until such time as the new methodology is implemented, facilities shall be paid via the methodology in place as of December 31, 2000. The difference between the two methodologies shall be calculated and the sum shall be paid, on a per visit basis, in the fiscal year immediately following implementation of this new methodology.

For services provided on or after January 1, 2001 by FQHC's participating in managed care, supplemental payments will be made to these FQHC's that will be equal to 100% of the difference between the facilities reasonable cost per visit rate and the amount per visit reimbursed by the managed care plan.